Office of Inspector General

Prepared for the Secretary of Health and Human Resources Study of the OIG July 23, 2002

"One of the profound responsibilities of any Government is to provide for its most vulnerable citizens."

Tommy Thompson,

Secretary of Health and Human Services,

2002

Goals of the study:

- Examine the ***current role*** and ***responsibilities*** of the OIG
- Make recommendations regarding the future role and placement of the OIG

Goals of this Presentation:

- Understand how Virginia arrived at the need for independent oversight of MHMRSA Services
- Current OIG Role
- Current OIG Responsibilities

Background Points: Government and MH/MR/SA

- MH, MR and SA services have a different relationship with government than health services.
- For MH and to a lesser extent SA, this is due to historical precedent set by the operation of state asylums, and to the relationship mental illness and substance abuse have with government public safety interests.
- For MR this is due to historical precedent of state operated facilities and now to educational duties associated with IDEA. (Individuals with Disabilities Education Act)

Sources of Funding for MH and Health Services

	MH	Health
Public funds	53%	47%
Medicaid	19%	15%
Medicare	14%	21%
Other Federal	2%	4%
State/local	**18%**	**7%**
Private Insurance	27%	31%
Self Pay	17%	18%

Background Points: State Government and MH/MR/SA

- States have a unique role and responsibility in the provision of MH services.
- State Hospitals are the cornerstone of this relationship. This is being progressively altered with the increasing use of Medicaid for outpatient MH,MR and SA services. Medicaid is a state-federal partnership.

State Government and MH,MR SA Services

- Differences in state politics result in wide variability in availability and quality of MH, SA, and MR services available in different states.
- Within a state, there can be wide variability in the priorities placed on MH, MR and SA services which can result in fluctuations in financial and service commitment to this group of citizens.
- The effect of changing political interest in mentally disabled citizens is confounded in a state such as Virginia which has a powerful executive branch but does not allow second terms for a Governor.

Politics in Virginia

- Virginia continued to develop new facilities despite several national influences. Half of the currently operational facilities (8 of 15) were opened after 1974.
- By comparison, the national peak years of institutionalization for MH was 1955 and for MR was 1969.

State Government Roles

- The governor and the executive branch are charged with the responsibility to operate DMHMRSAS and thereby the state facility system.
- The governor and the general assembly fund the system through appropriation of general funds as well as establishment of medicaid programs and partnerships with local governments such as the CSB performance contract.

What if a State develops and maintains other priorities? (Enter DOJ)

- Between 1990 and 2002, the Federal Government through the Department of Justice conducted investigations of and found substandard conditions within 5 of our fifteen state operated facilities. (NVTC, ESH, CSH, NVMHI, and WSH).
- The DOJ cases are based upon a Violation of Civil Rights for Institutionalized Persons Act.

What Are CRIPA Rights?

- Persons who are institutionalized in a state operated facility have a right to active treatment in a safe environment.
  - A right to **Active Treatment** means a person can not be warehoused.
  - A right to a **Safe Environment** refers to the state's duty to provide a humane setting with reasonable staffing levels such that persons are treated and monitored safely.

II. Current OIG Roles

A. Inform the Governor and the General Assembly as to risks for ongoing CRIPA (and Olmstead) violations.

B. Promotion of quality care by contemporary national standards in programs operated and licensed by DMHMRSAS.

C. Increase accountability of the public funded MHMRSAS facility system to citizens of Virginia.

Tools for Reviewing Quality of Care

- **Investigate** possible errors in care and promote performance improvement for each critical incident and situation reviewed. (examples: Reviews of individual events and Mortality Review.)
- **Audit** ongoing application of clinical policy and procedure and promote performance improvement where needed. (examples: staff knowledge of abuse and neglect reporting requirements, adherence to DOJ agreements)

Investigation:

- Review of Sentinel Event
  - Primary review (our own investigation)
  - Secondary review (review the root cause analysis and process conducted by the facility)
- Review of Critical Incidents
  - All critical incidents resulting in medical attention to a consumer are reviewed
  - Share data with VOPA regarding trends

A. Reporting to the Governor and General Assembly regarding DOJ/CRIPA risks:

- At each facility each year we are now required to provide information regarding active treatment provided, staffing patterns and general conditions of each facility.
- OIG is participating in the Olmstead planning process.

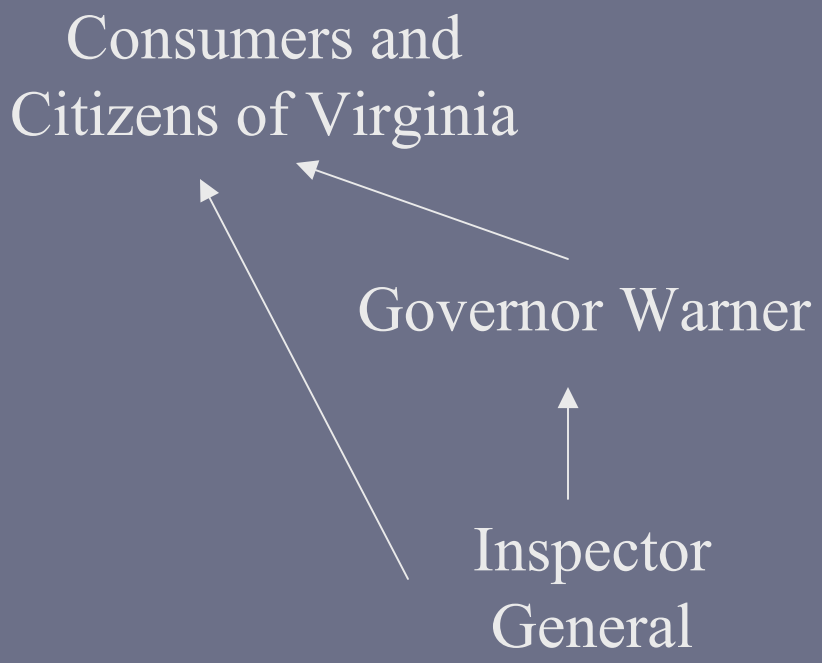
B. Promote quality of Care by National Standards

- Seen in all the inspection reports we do as well as special projects.
- One example of a current project is a report on the extent to which consumers and families have access to training on illness management and family education in our community system of care. These are two services that have been demonstrated in scientific literature to be of benefit in maintaining mental illness remission in community settings.

C. Accountability to the Public

- This is a critical role for the OIG.
- This is done primarily through the posting of our regular inspection reports on the OIG website.
- We also are working on attending regular board and stakeholder meetings to present our findings to concerned citizens. Plans for this include presentation of the OIG six-month report to the DMHMRSAS board, Pair, VAMI Board and other interested groups.

Reporting Structure



Reporting Requirements:

- Each inspection is accompanied by an inspection report which is submitted to the Governor.
- Semi-annual report to the Governor and the General Assembly.

III. Responsibilities: (p.8 2000 Annual Report)

- 1. *Provide oversight and conduct announced and unannounced inspections of DMHMRSAS operated facilities…to make recommendations to the Governor, Secretary HHR and Commissioner on methods to improve the quality of care in those facilities.*

Inspections:

- To date we have conducted over 60 inspections with over 600 recommendations made within the facility inspection reports.
- Our goal is to conduct one unannounced inspection at each facility each year.
  - We have exceeded this goal each year.

Inspection compliance Monitoring:

- Each recommendation is responded to through a plan of correction that is prepared by the facility and reviewed by the DMHMRSAS.
- Recommendations are monitored by the OIG and DMHMRSAS until they become inactive. This is done both through update reports provided by **each facility every six months on every outstanding recommendation** as well as on-site verification by OIG staff. Current budget cuts may reduce this function.

Critical Incidents

- Have reviewed over 1500 critical incidents.
- Subsequent actions may include:
  - Chart review
  - Laboratory review
  - Policy and Procedure review
  - Follow up at next on-site inspection
  - Complete inspection.

Responsibilities:

- 2. *To access any and all information related to the delivery of services, including confidential patient or resident information.*

Responsibilities:

- *3. To monitor any reports prepared by (DMHMRSAS) and critical incident data collected by the (DMHMRSAS) in accordance with regulations promulgated under §37.1-84.1 to identify issues related to quality of care, seclusion and restraint, medication usage, abuse and neglect, staff recruitment and training, and other systemic issues.*

Monitoring Responsibility:

- Now receive on a monthly basis, basic facility data. We plan to use this data to better inform on-site inspections and develop ideas as to trends across the system affecting the ability to provide basic quality services. This data includes: **census**, **staffing** and **staff turnover**, use of **seclusion and restraints, human rights abuse allegations** and investigations.
- Following DMHMRSAS directed projects such as medication budget shortfall, restructuring, Olmstead, and Hospital bed access crisis.

Responsibilities:

- *4. To monitor and participate in the promulgation of regulations by the State Mental Health, Mental Retardation and Substance Abuse Services Board.*

  OIG staff have reviewed every regulation promulgated by DMHMRSAS since the inception of the office. This has included approximately 6 regulations.

Responsibilities:

- *5. To receive reports, information and complaints from the Department for the Rights of Virginians with Disabilities concerning issues related to quality of care and to conduct independent reviews and investigations.*
- *To date we have worked with VOPA on a number of projects:*
  - *Critical incident data-base sharing*
  - *CVTC report on high incidence of injuries*
  - *Individual concern resulting in Peer review*
  - *Current project underway*

Current Resources:

- 3 Staff:
  - Anita Everett, M.D.
  - Cathy Hill, M. Ed.
  - Heather Glissman, B.A.
- Annual budget of about $300,000 which was reduced by 10% this year.
- 3 computers, 3 cell phones, 2 state vehicles 3 office chairs and one book shelf.
- Budget reductions have eliminated our ability to use professional consultants and impairs travel.

Moments of Satisfaction:

- Reporting on the serious inequities in the state operated training centers resulting in an increase in funding allowing staff to be increased to a more safe level. SWVTC was able to hire 30 new direct care staff.
- Reporting on the High resident injury rate with DRVD at on Training center. With implementation of the recommendations made in DRVD/OIG report, there was a dramatic reduction in resident injury rate within the first 6 months.

Differences:

- Reporting on the lack of occupancy permit for one facility which was based on unsafe exit from the building in the event of fire. The new building had been occupied for 4 years with no occupancy permit putting residents at serious risk should a fire break out.
- Reporting on the number of deaths and inconsistent management of deaths resulting in legislation requiring reporting for DMHMRSAS facility mortalities to the medical examiner as occurs for prisoners within correctional institutions.

Differences:

- Reporting on and subsequent remedy of the unlock able and easy access to a facility which houses some of our most vulnerable citizens late at night.
- Reporting on one facility with excessive overtime that was interfering with quality of care. This was remedied through immediate allocation of a small amount of additional funding.
- Reporting on and recommending the reworking of a peer review conducted by a facility of a serious incident based upon the superficial nature of the review and the fact that it did not look for genuine performance improvement opportunities associated with the incident.

Differences:

- Reporting on and guiding remedy for a facility that created virtually identical treatment plans for residents with no individualization.
- Reporting on and monitoring the development of a substance abuse initial treatment course for an institution that had 75% of its admissions diagnosed with substance abuse problems but was not addressing it clinically.

Future Possibilities:

- Increase authority to review conditions of those with mental illness residing in assisted living facilities and other community settings not licensed by MHMRSAS.
- Increase Authority to review condition of geriatric settings which house individuals with geriatric related mental illness such as Alzheimer's Disease.

Possible Placement:

- Maintain Status Quo.
- Consideration of role within Academic Medical Center, (I.e. UVA , VCU or EVMS)
- Consideration of transfer of role and responsibility currently within DMHMRSAS to OIG to take advantage of the independence OIG currently offers. (Evaluation, Human Rights, DOJ Compliance)

Summary:

- Reviewed the current roles and responsibilities.
- Provided information regarding the productivity and integrity of the office.
- Provided information regarding some possible future positions for the office.

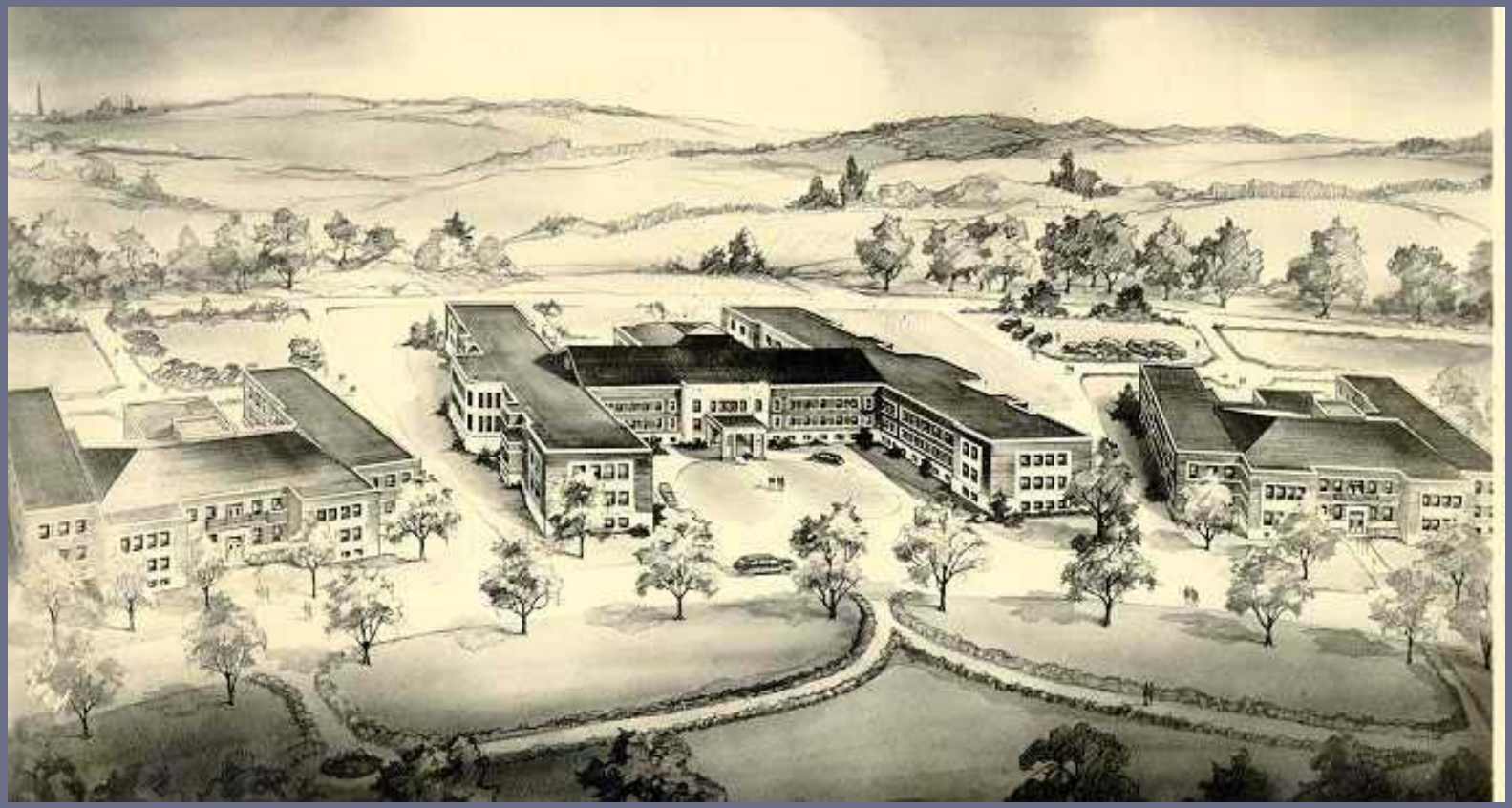
Music Therapy

Southwestern Mental Health Institute

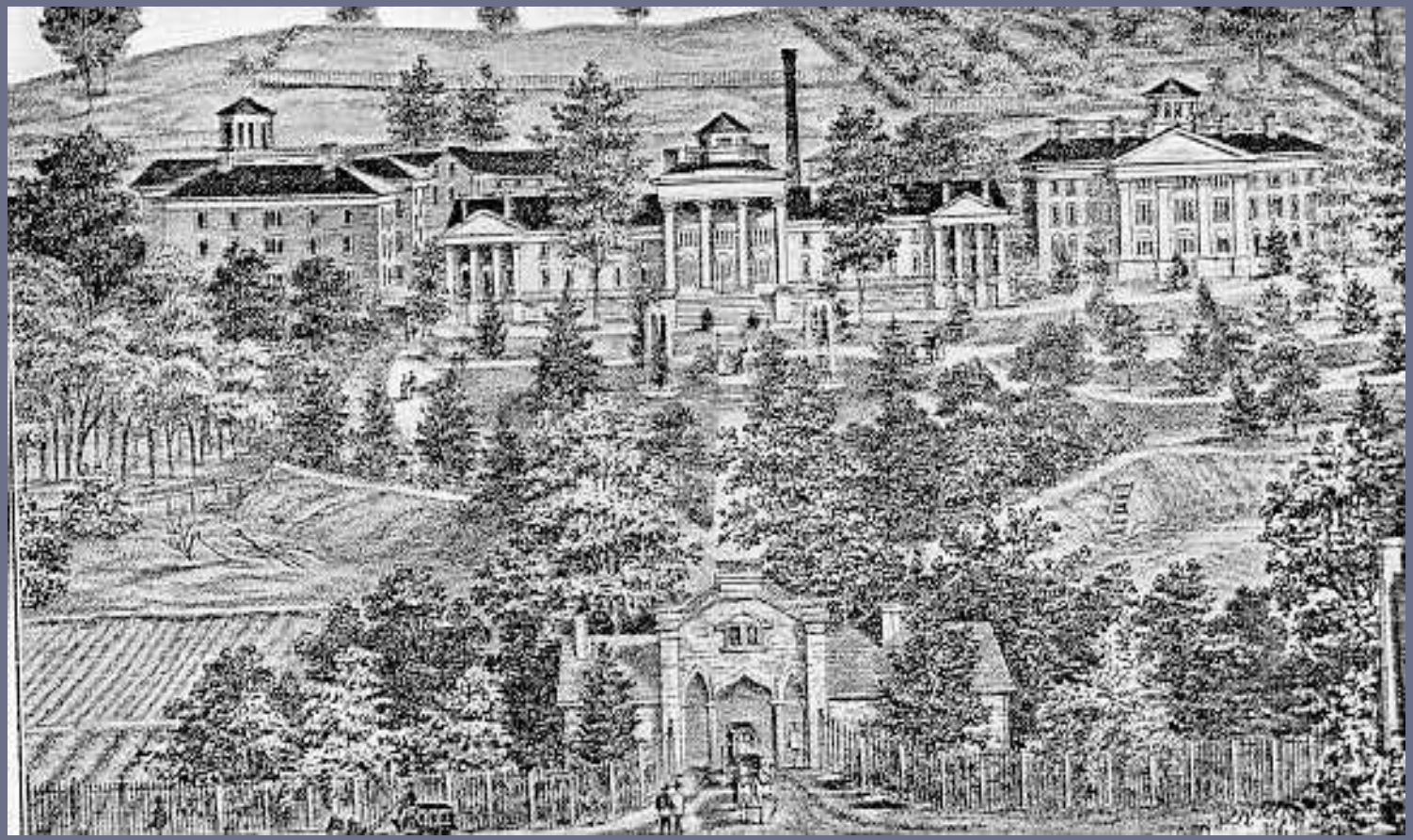
The Medical Staff at Western State Hospital circa 1850

Warehousing of the Mentally Ill

Peak Institutionalization



Western State Hospital 1825



Central State Hospital is founded in 1885

Southwestern State Mental Health Institute is founded in 1887